UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF MISSISSIPPI
NORTHERN DIVISION

THE UNITED STATES OF AMERICA — PLAINTIFF

VS. — CIVIL NO. 3:16CV00622CWR-FKB

THE STATE OF MISSISSIPPI — DEFENDANTS

VOLUME 9

BEFORE THE HONORABLE CARLTON W. REEVES
UNITED STATES DISTRICT JUDGE
AFTERNOON SESSION
JUNE 11, 2019
JACKSON, MISSISSIPPI

REPORTED BY: BRENDA D. WOLVERTON, RPR, CRR, FCRR
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*** DAILY TRANSCRIPT ***

APPEARANCES:

FOR THE PLAINTIFF:	MS. REGAN RUSH MS. HALEY VAN EREM MR. JORGE MARTIN CASTILLO
FOR THE DEFENDANT:	MR. JAMES W. SHELSON MR. REUBEN V. ANDERSON

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THE COURT: Is there anything we need to take up before we call the next witness?

MS. RUSH: No, Your Honor, not from the United States.

THE COURT: Mr. Shelson?

MR. SHELSON: No, Your Honor.

THE COURT: All right. The government may proceed.

MR. CASTILLO: Good afternoon, Your Honor.

THE COURT: Good afternoon.

MR. CASTILLO: I'm Jorge Castillo and I represent the United States, and I would like to call Dr. Beverly Bell-Shambley as our next witness.

THE COURT: Okay. All right.

BEVERLY BELL-SHAMBLEY,

having first been duly sworn, testified as follows:

THE COURT: I think you have been here a little while. Were you here for earlier testimony?

THE WITNESS: I was, yes, sir.

THE COURT: Do you recall the instructions I gave everybody else?

THE WITNESS: Yes, sir.

THE COURT: All right. So speak loudly and clearly and, if you will, state and spell your name for the record.

THE WITNESS: Yes. Beverly Bell-Shambley. B-E-V-E-R-L-Y. Bell, B-E-L-L, hyphen or dash, Shambley, S-H-A-M-B-L-E-Y.

THE COURT: Thank you. Dr. Shambley or Ms. Shambley? What was it?

THE WITNESS: Dr. Shambley.

THE COURT: Thank you, Dr. Shambley.

Mr. Castillo, you may proceed.

MR. CASTILLO: Thank you, Your Honor.

DIRECT EXAMINATION

BY MR. CASTILLO:

Q Good afternoon, Dr. Bell-Shambley.

A Good afternoon.

Q What is your profession?

A Clinical psychology.

Q And were you part of a team hired by the United States?

A Yes, I was.

Q And as part of that team, what were you asked to do?

A I was asked to do clinical review of individuals who were assigned to me.

Q How many individuals did you review?

A I was assigned 26 individuals.

Q Can you briefly describe your overall conclusions?

A Yes. My overall conclusions were that the individuals that I reviewed could have avoided or spent less time in the hospital had they received reasonable and appropriate community-based services.

I also concluded that the provision -- there were

inconsistencies in the provision of reasonable and appropriate community-based services such that individuals were at risk of going back into the hospital.

THE WITNESS: I'm sorry. I'll slow down.

A The first conclusion was that individuals could have avoided or spent less time in the hospital setting had they received reasonable and appropriate community-based services. I also concluded that there were inconsistencies in the provision of community-based services such that individuals were at risk for returning to hospitals.

BY MR. CASTILLO:

Q Before we take a deeper dive into those conclusions, let's discuss your background for a minute. Where did you train to become a psychologist?

A I trained at the University of Georgia and also completed a clinical internship at the V.A. Hospital in Kansas City, Missouri.

Q When did you graduate?

A I graduated in 1985.

Q With what degree?

A With a Ph.D. in clinical psychology.

Q And after graduation, where did you go to work?

A I went to work with the Department of Mental Health in the State of Alabama.

Q And where did you work in the Department of Mental Health

of Alabama?

THE COURT REPORTER: I'm sorry.

MR. CASTILLO: I'm sorry. Yes, ma'am.

THE COURT: You can answer.

THE WITNESS: All right.

A I worked -- I began my employment with work in a hospital in Tuscaloosa.

BY MR. CASTILLO:

Q In total, how many mental health facilities did you work for the state of Alabama?

A I worked in four different hospitals.

Q And over how many years combined did you work in those four facilities?

A Twenty-two years.

Q And in those 22 years, what kinds of jobs did you have?

A Jobs that involved the direct provision of psychological services, evaluations and treatment, clinical supervision of other clinical staff, administration as well as administrative supervision.

Q Did your clinical work during those years include assessing what community-based services were available and appropriate for your patients?

A Yes.

Q After those 22 years in Alabama mental health facilities, what did you do next?

A I was promoted to the position of director of mental illness facilities and began working out of the central office.
Q What did that job entail?
A Generally, that job entailed the supervision of the hospital directors of the mental illness hospitals.
Q How long did you hold this position?
A I held that position from 2007 until 2012.
Q And in 2012, what did you do next?
A In 2012, in July of 2012, I was appointed to the position of associate commissioner for the mental health and substance abuse services division.
Q Generally speaking, what did that job entail?
A Generally speaking, that job entailed collaboration -- well, supervision and oversight of the continuum of services within the mental health and substance abuse division; oversight of the hospital system as well as oversight of contractual relations with community providers; and certainly entailed collaboration with other stakeholders.
Q How long did you hold this position?
A I held the position from -- four years from July of 2012 until my retirement the end of October 2016.
Q During your jobs either as director of MI facilities or as associate commissioner for the Department of Mental Health for the State of Alabama, were you involved in any statewide initiatives related to community-based services?

A Yes.
Q Like what?
A Statewide -- a number of different statewide initiatives, but a large part of my time in the position of associate commissioner related to the downsizing of the state hospital units and ultimately the closure of state hospitals and then the work towards transitioning those services to the community and expanding community-based services.
Q While you were in the central office of the Department of Mental Health in Alabama, why was Alabama in this transition in expanding community services?
A Varied reasons. But the transition of downsizing hospitals, recognizing that certain services could be provided more -- less costly and more effectively in the community, started even with the *Wyatt v. Stickney* case from the '70s, a recognition of our need to assure that we were in compliance with ADA and *Olmstead*, as well as, honestly, budgetary constraints that required us to think about things in a different way to assure that we were getting the best results that we could for the consumers we served with the dollars that we had.
Q What was your role in this broader effort to transition to the community services?
A My role started in the position of director of MI facilities where we recognized that we needed to develop a

process for evaluating those individuals who were in the hospital to determine what services in the continuum we needed more of or what services we didn't have at all in order to meet the needs of those individuals who were currently in the hospital who were going to be transitioned into the community.

So assistance from a clinical perspective, although the position was primarily administrative, but assisting in developing and evaluating a tool for gathering that information, looking at and analyzing the results of the data as a result of those clinical evaluations at that time, looking at what services were identified as being needed, and then evaluating with a team of individuals, with a team of individuals, funding, how do we go about funding the identified services.

Q During your years as associate commissioner, what were you able to accomplish with regarding this transformation?

A We were able to accomplish the downsizing of the need for state hospital beds in terms of acute as well as extended-care services. We were able to close three hospitals and transition those individuals to community-based services. We were able to expand the provision of supported housing and expand peer services.

Q Just to be clear, did Alabama close all its state hospitals?

A No. No.

Q Can you describe generally the population of individuals in state hospitals who were transferred to the community?
A The individuals who were transferred to the community were individuals who had a range of diagnoses, but many with diagnoses of serious mental illness, individuals who had been in the hospital for -- some for many years, individuals who had had multiple admissions to the hospital, and certainly individuals range in terms of their age as well as race and gender and where they were from throughout the state.
Q Have you stayed active in the field of psychology since retiring from the Department of Mental Health?
A Yes, I have.
Q In what ways?
A Even during the time of my employment with the Department of Mental Health, I maintained a private practice and I have continued to see individuals for psychological services, evaluations, assessments and therapy. I have also continued involvement with professional organizations such as the American Psychological Association and local organizations such as NAMI, and continued to maintain a license, so that required continuing education, participation in continuing education, webinars, attending seminars, readings.
Q And again, we want to slow down just a little bit for the court reporter. You mentioned NAMI. What does that stand for?
A The National Alliance of Mental Illness.

MR. CASTILLO: Your Honor, at this time we tender Dr. Bell-Shambley as an expert in psychology, serious mental illness, and community-based mental health assessments.

THE COURT: Any objection from the government? From the State of Mississippi, which is the government too.

MR. SHELSON: No, Your Honor.

THE COURT: All right. Dr. Bell-Shambley will be allowed to testify as an expert in the designated areas.

MR. CASTILLO: Thank you, Your Honor.

BY MR. CASTILLO:

Q So let's turn back to the review that you completed in Mississippi. Can you briefly summarize how you completed that review?

A Yes. A tool was developed to guide the process for completing interviews. I was assigned the 26 individuals to complete the interviews on, spent time interviewing those individuals as well as, when available, interviewed family members and also conducted some interviews with community mental health providers, personnel from the community mental health centers, also reviewed the records that were available to me, records from State Hospital admissions, records from community hospital stays, records from their community mental health center services, and some records from community hospitals.

Q Did you write down your findings?

A I did.
Q Where?
A In a report that I submitted.
Q When did you first submit your report?
A The report was submitted in the summer of 2018, I believe, around the end of July of 2018.
Q After your deposition in this matter, did you have any changes to your report?
A I did.
Q What were those changes?
A There was one individual that had a recommendation for a service that was an error.
Q And what change did you make to your report?
A The removal of supported housing from the recommendations.
Q How many words in total changed from your first report to this revised report?
A Two.
Q And apart from those two words, the report was essentially identical?
A Yes.
Q There is a binder in front of you. Can you please open your binder to Plaintiff's Exhibit 408?
A Yes, I see it.
Q Is that your revised report?
A Yes. It appears to be.

MR. CASTILLO: Your Honor, the revised report contained in the binder is marked Plaintiff's Exhibit 408 and has been preadmitted into evidence.

THE COURT: All right.

BY MR. CASTILLO:

Q Dr. Bell-Shambley, did you make any additional corrections to this revised report?

A Yes, I did.

Q Please in your binder turn to the next tab marked Plaintiff's Exhibit 408A.

A I see it.

Q Are you there? What is this document?

A This is the document that lists the corrections that I made to the report, basically corrections related to tallying errors.

Q Are there any corrections to the substance of your report?

A No.

Q Does your report, along with the corrections we just discussed, accurately reflect your conclusions and opinions?

A Yes.

MR. CASTILLO: Your Honor, I move Plaintiff's Exhibit 408A into evidence.

THE COURT: Any objection from the State?

MR. SHELSON: No, Your Honor.

THE COURT: Okay. PX-408 will be received into

evidence.

MR. CASTILLO: And just for a clarification, Your Honor, it is PX-408A.

THE COURT: Thank you.

(EXHIBIT PX-408A MARKED)

BY MR. CASTILLO:

Q Dr. Bell-Shambley, turning again to the tasks you had in this case, what specific questions did you answer for the people that you reviewed?

A I answered the questions of whether for these individuals they could have avoided or spent less time in the hospital had they received reasonable and appropriate community-based services. I addressed whether these individuals, in my opinion, were at serious risk of state hospitalization. I addressed whether they were opposed or not opposed to receiving services in the community. And I addressed whether if they were appropriate -- whether they were appropriate for community-based services and, if they were, what services would be of benefit to them.

Q We're going to go over each of these four questions in a minute. But first, do you have a demonstrative that reflects your overall findings with regards to these four questions?

A Yes.

MR. CASTILLO: May I approach, Your Honor?

THE COURT: You may.

BY MR. CASTILLO:
Q (Tenders document.) Is this that demonstrative?
A Yes.
Q Does this slide accurately depict what you found?
A Yes, it does.
MR. CASTILLO: Your Honor, this demonstrative is marked Plaintiff's Demonstrative Exhibit 12 for identity purposes.
THE COURT: All right. It will be marked for ID purposes.
(EXHIBIT PDX-12 MARKED FOR IDENTIFICATION)
BY MR. CASTILLO:
Q Let's march through this. You answered whether the person in your review could have avoided or spent less time in a state hospital. How many clients in your review could have avoided or spent less time in a state hospital?
A It was my finding that all of the clients in my review could have avoided or spent less time in the hospital.
Q And generally speaking, what were the reasons that that was your finding?
A That was my finding because there were -- my knowledge of community-based services and my experience with individuals who were very much similar to the individuals in my sample, and the awareness that there are community-based services that could meet the needs that are identified for those individuals.

Q The next question is how many people in your client review did not oppose community-based services. How many did you find did not oppose?
A I found that none were opposed to receiving services in the community.
Q How did you go about determining this?
A For most of the individuals I made the determination by directly asking them if they had a preference or if they were opposed. There were two individuals who did not respond directly to interview questions and I came to a decision based on review of their records. And then there was one individual in my sample who was deceased.
Q Were you surprised that no one opposed services in the community?
A No. No, I was not surprised.
Q Why not?
A Again, based on having worked for 30 plus years with individuals who are recipients of mental health services, I have not come across anyone who desired to receive services or live in a hospital setting if other appropriate settings were available to them. And I doubt that there is anyone who would make the choice, an informed choice, to live in a hospital setting. So, no, I was not surprised.
Q Turning to the next question, how many individuals did you find were appropriate for community-based services?

A I concluded that, again, all of the individuals were appropriate for community-based services.
Q In general, why did you find people in your review were appropriate for community-based services?
A Following analysis of all the information available to me, the interview data, information from reviewing records, I did not see -- I saw symptoms, behaviors for which community-based services were available. I did not see behavior symptoms for which I didn't see community-based services. So I felt like there is a match here of their symptom presentation behaviors and what services are available. And based on that, I felt like they were all appropriate.
Q How many people in your client review were in the hospital when you interviewed them?
A Four.
Q These people were actively committed at the time of your interview. Why did you think they in particular were appropriate for community-based services?
A Again, when I looked at the services that they were receiving in the hospital and I looked at the community-based services, the array of community-based services, I did not see that there were services that they were receiving in the hospital setting that could not have been provided in a community setting. And, in fact, when I look at the documentation in the records, some of these individuals were

being referred for community placement but it had not occurred.
Q And just to be precise, did you find or did you make any specific findings for any person in your review whether they were appropriate for the community at the moment in which they were admitted to the state hospital?
A No. No, I did not.
Q For this third question, you noted that you also identified community-based services that you found were appropriate for each individual. How did you make that determination?
A I made the determination again based on knowledge, experience, awareness of the literature on community-based services and the effectiveness of those services when implemented appropriately, and I looked at the symptomatology and the behaviors for the individuals in my sample and looked to determine are there symptoms, behaviors for which there aren't any community-based services that could reasonably be effective in remediating those symptoms.
THE COURT REPORTER: I'm sorry?
THE WITNESS: I'm sorry. That could reasonably be effective in treating those symptoms.
BY MR. CASTILLO:
Q So you made a match?
A Yes.
Q So let's discuss the serious risk question. For which people in your review did you analyze the question of serious

risk? How many?
A Twenty-five. No, I'm sorry. I am so sorry.
Q That's okay. Let me ask the question again. For how many people in your review did you analyze the question of serious risk?
A Twenty-one.
Q For the other five people in your review, why did you not analyze the question of serious risk?
A The question of serious risk of hospitalization. And I did not analyze that for the four individuals who were already in the hospital, nor did I look at that for the individuals who -- who was deceased.
Q So the 21 people in your review that you did analyze the question of who was at serious risk of institutionalization in a state hospital, how many did you find were indeed at serious risk?
A Seventeen.
Q And why were they at serious risk?
A Because absent them receiving appropriate community-based services, I felt like they were at risk for reoccurrence or worsening of symptoms and ultimately a return to the hospital.
Q And were they receiving the services that would ameliorate that risk?
A For most of the individuals in my sample, they were not.
Q What services did you recommend frequently for folks -- for

people who were at serious risk of hospitalization?
A I recommended PACT services based on the aspects of that delivery model to be comprehensive and intense enough to meet the needs of the individuals.
Q Now that we've covered an overview of your findings, let's discuss some of these conclusions in more detail, and I would like to start with the transition planning that you observed. What did the transition planning from the state hospital largely entail for the individuals that you reviewed?
A Okay. The transition planning largely entailed someone, usually the social worker at the hospital, scheduling an appointment with the next provider, the community provider, and then passing that information on to the recipient near or at the time of discharge.
Q What was the coordination between the state hospital and the community-based providers that you were seeing during this transition planning?
A For the most part, there was not a coordination of discharge planning. I did not see consistent engagement of the community providers or family, for that matter, in discharge planning.
Q And what happened generally after people went back to the community after experiencing transition planning like this?
A In general, without appropriate discharge planning, individuals were not receiving the level or intensity of

services in the community. That resulted in a deterioration of their condition and ultimately return to a hospital setting.
Q How did the transition planning you observed affect the individual's ability to cope with the symptoms of their mental illness in the community?
A It affected -- if you're not receiving appropriate services, if you're not receiving the treatment that you need, if you're not receiving the medication that will be beneficial in stabilizing your symptoms, I saw a reoccurrence of symptoms. I saw a process that led towards a return to hospital setting.
Q How would you describe the effectiveness of the transition planning that you observed in the review?
A It was not effective.
Q And what impact does ineffective transition planning have on a person's risk of rehospitalization?
A From experience and the literature, it's clear that if an individual is not connected with the services that they need when they transition from the hospital to the community, it lessens the likelihood of them being able to be successful and maintain stability.
Q Let's discuss transition planning through the lens of a person in your client review. Tell me about person 3 whom you begin discussing in your report, Plaintiff's Exhibit 408, on page 19. Who is person 3?
A Person 3 is a 25-year-old -- was 25 at the time that I saw

him -- African-American male who was suffering from untreated symptoms of his illness. He was living in the home with his parents. He had gone to high school, had gone to Job Corps, completed Job Corps and returned home, had played basketball and had worked with his father in his auto shop.

Q When did this young man begin to show signs of mental illness?

A He began to show signs -- according to the information available to me, he began to show signs of mental illness in 2013, shortly after returning from Job Corps.

Q How many times has he been to the State Hospital?

A He has been admitted to the State Hospital three times.

Q Generally speaking, what led to those three admissions?

A Generally speaking, nonadherence or noncompliance with medication, resulting in an increase or worsening of symptoms of psychosis, threatening behavior, aggressive behavior, self-injurious behavior.

Q What community services did you ultimately recommend for this young man? Let me rephrase that. What community services did you ultimately find that this young man was appropriate for?

A I found that he was appropriate for services -- PACT services. At the time that I saw him, I also included in addition to specifically stating the PACT services, he was acutely in need of medication. He was acutely ill and I felt

like the intensity of services that could be provided by PACT to assist in getting him stable was what was needed at the time.

Q How would PACT assist in keeping him stable and help keep him in the community?

A Here is an individual who has had three admissions to the hospital, who has been identified as having some deficits in insight and judgment and issues with compliance with medication. And so the -- having individuals, a team of individuals, professionals, available to intervene in the crisis situations, to assess and evaluate what his needs were at the time without it being dependent upon him seeking out services -- because the likelihood of him on his own seeking out services is not likely -- again, based on the intensity and the comprehensiveness of the services provided by PACT, it is my opinion that that's what he needed.

Q Would receiving those intensive services like PACT help him avoid future hospitalizations?

A Most likely, yes.

Q Over time, is it possible that he would be able to rebuild his life, start working again, or assuming other goals?

A Certainly that would be the hope. And based on experience and seeing other individuals who indeed are able to rebuild their lives and experience recovery and stability in the community, I would say yes.

Q Let's walk through each of his three State Hospital admissions one at a time. Please turn to your binder at tab Plaintiff's Exhibit 1099. Are you there?
A I'm there.
Q What is this document?
A This document is a discharge summary of person 3's first admission to the hospital that included an admission date of September 16, 2014, with a discharge of February 23rd, 2015.
Q Have you seen this document before?
A Yes, I have.
Q When?
A As part of the review of his records.
MR. CASTILLO: Your Honor, I move to admit Plaintiff's Exhibit 1099 into evidence.
THE COURT: Any objection from the State?
MR. SHELSON: No, Your Honor.
THE COURT: PX-1099 will be received into evidence.
(EXHIBIT PX-1099 MARKED)
BY MR. CASTILLO:
Q If you turn -- if you turn to the second page of Plaintiff's Exhibit 1099, at the bottom where it says hospital course, --
A Yes.
Q -- there is a clinical progress note dated September 22nd, 2014. Towards the end of that note, it states, "Poor insight

and lacks judgment." Do you see that?
A I see that.
Q What do you make of this statement?
A That the individual, the clinician making this statement is of the opinion that this individual has deficits in his understanding and acceptance of his illness. That's the poor insight. And that he lacks the ability to make right or appropriate decisions.
Q And turning to page 4 of Plaintiff's Exhibit 1099 where the heading "Mental Status Exam on Discharge" is, do you see that it also states, "Insight and judgment poor"?
A I do.
Q Given his poor insight and judgment throughout his five-month hospitalization, how important is effective transition planning for person 3?
A It would be very important.
Q Why so?
A Recognizing that this individual is not -- based on the clinicians evaluating him, is not demonstrating appropriate insight or awareness of his illness, is not demonstrating the ability to make appropriate decisions with respect to his illness or the need for treatment or continuation in treatment, it would be important for there to be a comprehensive transition plan to assure that there were no gaps in his receiving services.

Q Might effective transition services help prevent those gaps from occurring?
A Yes.
Q If you turn to page 5 of Plaintiff's Exhibit 1099 where it says, "Plan/Recommendations," can you read out loud the portions of this document that reflect how East Mississippi State Hospital actually transitioned person 3 to the community?
A Yes, I can. It indicates, "Direct discharge home on 2-23-2015 to family.

IRS encouraged to continue to abstain from the use of drugs and alcohol and obtain a sponsor, attend meetings. Also, he was encouraged to attend follow-up appointment scheduled on 2-26-15 as instructed per social worker.

4. IRS also encouraged to follow up with his private care provider for management of his medical condition.

And IRS reminded Lithium and Depakote levels are required for appropriate management of medication."
Q You just read IRS. What does IRS stand for?
A My interpretation is that's individual receiving service.
Q So based on this plan, how would you describe the transition services person 3 received during his first state hospitalization?
A This -- deficits are an absence of true transition planning.

THE COURT REPORTER: I'm sorry?

A What is documented here represents an absence or deficits in true transition planning.
BY MR. CASTILLO:
Q Can you elaborate on that?
A True transition planning would engage certainly family members if -- with the approval of the recipient. It certainly would involve the community mental health center or community provider who is going to be providing services for the individual once they transition out of the hospital. For the continuity of care, what I see here does not indicate the coordination with the community provider or the engagement with the family.
Q How about in the rest of person 3's record of his first hospitalization? Did you see evidence of engagement with his family or the community mental health provider?
A I do not recall seeing such.
Q On page 5 of 1099, it also says that person 3 was encouraged to abstain from drug use and attend follow-up appointments. Based on his needs, is encouragement going to be effective for person 3?
A I think encouragement alone is not going to be effective.
Q Why not?
A Again, as I've said, here is an individual who has already been identified as having deficits in insight and judgment, who has had a history of noncompliance with medication. Without

someone doing more than just encouraging, but also assisting and making sure that he gets to the appointments and making sure that services are available to him that if he is not going, then we're going to bring the services to him, that's the kind of service that would go a long way in ensuring his stability.

Q Receiving that sort of connection in the hospital?

A An awareness of who the next provider of care is going to be and awareness of where exactly he will receive the services or who is going to provide the services. Those are the kinds of plans, transition planning, that should occur while in the hospital.

Q And, in fact, was person 3's transition into the community after his first admission successful?

A No.

Q What actually happened when person 3 went back home?

A When he returned home, there is no indication in the information available to me that he received community-based services. And ultimately, he experienced a worsening, a reoccurrence and worsening of symptoms, and he ended up returning to the hospital.

Q How soon after his return after his first discharge did he go back to the State Hospital?

A It was a matter of months.

Q Let's turn now to that second admission. If you can please

turn to Plaintiff's Exhibit 1100 in your binder and let me know when you're there.

A I am there.

Q What is this document?

A This document is the discharge summary of person 3's second admission to the hospital, to East Mississippi State Hospital, from October 28th of 2015 to December 8th of 2015.

Q Did you review this document during your client review?

A I did.

MR. CASTILLO: Your Honor, I move to admit Plaintiff's Exhibit 1100 into evidence.

THE COURT: Any objection?

MR. SHELSON: No objection, Your Honor. And to speed things along, the next exhibit, 1101, we do not object to that one either.

THE COURT: All right. PX-1100 and 1101 will be admitted for ID purposes -- or, excuse me, admitted in evidence?

MR. SHELSON: Yes, sir.

THE COURT: Okay. Will be received in evidence. Excuse me. You may proceed.

(EXHIBITS PX-1100 AND PX-1101 MARKED)

MR. CASTILLO: Thank you, Your Honor.

BY MR. CASTILLO:

Q Can you turn to page 5 where it says "Disposition" for his

second hospital admission?
A Yes.
Q And please read aloud the portions where it describes what East Mississippi State Hospital did to transition person 3 back in the community this time around.
A "IRS was encouraged to attend his follow-up appointment scheduled on Mondays and Wednesdays at 2:30, community counseling service. IRS also encouraged to follow up with his private care provider regarding his medical diagnosis. IRS refused vital signs at time of discharge."
Q How would you describe the transition services person 3 received during his second admission?
A Essentially the same as the time of the discharge from his first admission, an absence of true transition planning.
Q Is encouragement alone appropriate for a person with a mental illness history like that of person 3?
A No.
Q And on the same page below "Disposition," it says "Prognosis." Do you see that?
A Yes.
Q Can you read what the prognosis states?
A "Prognosis is guarded due to his history of noncompliance and substance usage."
Q What does the prognosis of person 3 tell you?
A It tells me that the clinician rendering this prognosis is

not confident, not at all confident that he will be successful in his return to the community based on noncompliance with medication and substance use.

Q To put it simply, is this a prognosis that they expect person 3 to succeed when he is discharged in the community?

A No, it's not.

Q Is encouragement alone appropriate to transition -- an appropriate transition plan for a person with a guarded prognosis due to a history of noncompliance and co-occurring illness?

A No.

Q Why not?

A For the same reasons as I've said. This individual who has deficits in insight and judgment, has a history of noncompliance, has substance use, and has a diagnosis of a serious mental illness is going to need more than just encouragement, is going to need assertive, aggressive treatment to assure that his illness is managed and that he receives the services needed to promote his movement to recovery.

Q Was there any evidence that the State Hospital was providing more in transitions planning in the rest of person 3's record for his second hospital admission?

A Not that I recall.

Q Back to your binder, please turn to Plaintiff's Exhibit 1101 which was previously admitted into evidence. Can you

describe this document, please?
A Yes. This is a discharge summary of person 3's third admission to East Mississippi State Hospital dated for dates July 1 of 2016 admission and discharge October 31, 2016.
Q How old is person 3 at this point?
A He is 23 years old.
Q Can you turn to page 4 of Plaintiff's Exhibit 1101 where it says "Disposition"?
A Yes.
Q Can you please read out loud the parts that describe what East Mississippi State Hospital did to transition person 3 back to the community in his third State Hospital admission?
A "Discharged on October 31st, 2016, home to his family. Psychiatric aftercare appointments have been scheduled with the local mental health center. Highly encouraged to follow up for medical concerns with the healthcare provider of his choice. Prescriptions for discharge medications have been provided at discharge. Highly encouraged abstinence from alcohol and drug use. Highly encouraged medication compliance and treatment compliance at discharge. However, he remains skeptical that he truly needs to take psychiatric medications at home."
Q Where it says he remains skeptical that he truly needs to take psychiatric medications at home, is that a description of person 3?
A That's my -- yes.

Q And how did this transition -- the transition services person 3 received in his third hospital admission, how would you describe it?
A I would describe it as largely similar, the same as for the first and second discharges, an absence of transition planning.
Q Again, how successful do you think it will be to highly encourage person 3 to follow up with community-based service providers?
A Encouragement, even high encouragement, in and of itself will not be sufficient.
Q On your screen now you can see the portions of the discharge summaries that we just discussed.
A Yes. I see it.
Q How much time elapsed between the first admission and the last discharge for person 3?
A I'm sorry. Could you repeat the question?
Q Between the time of his first admission to East Mississippi State Hospital and his last discharge, how much time has elapsed?
A Approximately two years.
Q And over those two years, did you observe any improvements in the transition services that person 3 received?
A I did not.
Q How did you react, seeing identical discharges for person 3 admission after admission after admission?

A It was disheartening. But my reaction was more to seeing the condition of this young man when I saw him.
Q And let's fast-forward to when you did interview him. When was that?
A I interviewed him on March -- March 26 of 2018.
Q And how was he then?
A Then he was in the home. He was in the kitchen area of the home. He was moving about kind of aimlessly in that area with movements of his hands and arms, appeared to be mumbling to himself with movement of his lips, blinking of his eyes. Appeared, in my clinical opinion, to be experiencing auditory and visual hallucinations.
Q What services was he receiving when you met him?
A He was not receiving any services.
Q What was your reaction to seeing him this way?
A Extremely frustrating, and particularly frustrating when I hear from his family that he has been in the state that I am seeing him in in March of 2018 since the latter part of 2016, and witnessing their frustration that they had reached out and sought to get services for him, and those attempts to get service had not been responded to. They had not been able to get medication for him. They had not been able to get anyone to come to the home to evaluate him.
Q You spoke with his parents?
A I did.

Q How were they doing with the situation?
A They were doing the best they could. They were frustrated. They were seeking help. They were doing the best they could to have maintained this individual in the home for really closer to two years without medication, without treatment, and able to keep him safe. But they clearly were beginning to reach the end of their rope and feeling that perhaps a return to the hospital was the only option available.
Q You recommended PACT for this young man. Is there any evidence that he was considered for PACT services during any of his state hospitalizations?
A I did not see any evidence of such.
Q What community mental health region does person 3 live in?
A Region 7.
Q Can you give us a rough sense of what part of the state that's in?
A That's in the eastern part of the state.
Q Is PACT available in Region 7?
A At the time that I saw him, it was not available. I don't know if it currently is.
Q Did you find that person 3 was at serious risk of State Hospital admission?
A Yes, I did.
Q Why?
A Because he is acutely ill and he has been without

appropriate community-based services for more than a year.
Q Putting aside transition planning for a minute, I would like to focus in some more detail about the service intensity of the community-based services that you saw in Mississippi. First, what does a high-intensity community-based service look like?
A High-intensity community-based services are those services that -- it looks like PACT. Let me just say it looks like PACT. It's services that are available to meet the needs of the individual on an almost 24/7 basis. It's services that are of the right variety and array to meet the needs of the individual.
Q And where can high-intensity community-based services be received?
A In the community, in the individual's home, wherever is most appropriate for that person to receive the services. Those --
Q I'm sorry. Did I interrupt you? I interrupted you. Do you have anything else you wanted to say?
A I was just going to add that it's the kind of services that are person-centered, and so those intense services would be guided and directed by an individual evaluation of the person's needs.
Q As a point of comparison, what does a low-intensity community-based service look like?

A When I think of low-intensity community-based services, I think of traditional office-based services where the individual is given an appointment time and they are expected to present themselves to the office or to the practitioner or clinician for their services.
Q In a traditional office-based treatment setting, who generally has responsibility for ensuring that the individual continues with treatment?
A Ultimately it is the responsibility of the individual to get themselves to the appointed place at the appointed time to receive the services.
Q And then turning back to the high-intensity services, who has a responsibility for following up to ensure an individual continues with treatment?
A It is a shared responsibility with those clinicians providing the services taking on more responsibility and ownership to assure that the individual gets what they need.
Q And why might the level of intensity vary over time or across patients?
A I'm sorry. I think my reaching for a tissue distracted me.
Q No problem. Do you need a minute?
Why might the level of intensity vary over time or across patients?
A Okay. There are fluctuations in individuals' experience of symptoms, experience of life. There are stressors that may

come and go, and so the intensity of the need for services is expected to vary. So there are times, particularly when someone is transitioning from a more controlled environment, one would expect the intensity of service in the community to be greater. As that person is connected with appropriate community services, acclimated to a new living environment, one might expect the intensity of those services to decline. A loss, a decision to discontinue medication may result in the need for more intense services. So it may vary based on the needs and the presentation of the individual.

Q Were there people in your review who needed intensive community-based services?

A Yes.

Q And in general, were you seeing that they received the intensity of services that they needed?

A In general, no.

Q What impact did that have on the individuals in your review?

A The impact, in general, was that they experienced a reoccurrence of symptoms and in many cases a return to commitment in the hospital setting.

Q Is there a particular example of an individual you reviewed in Mississippi who wasn't getting the intensity of services that he or she needed to stay out of the hospital?

A Yes.

Q What example might that be?
A Person 18.
Q And in case you need it, person 18, you begin discussion of her on page 81 of Plaintiff's Exhibit 408. Can you please generally describe who person 18 is?
A Yes. Person 18 is, again, at the time that I saw her, a 55-year-old African-American woman who was living in the home with her mother and brothers. She had children. She reported that she had had employment in the past, working hanging up clothing and had worked at a motel. She expressed interest in working again. I think one of her statements was, "There is nothing like having your own money." And she expressed interest in going to school and learning to bake, with a particular interest in baking cakes. She also expressed interest in living, living as independently as she could.
Q And what community mental health region was she in?
A Region 7.
Q Was she hospitalized in 2017?
A Yes. She had two hospitalizations in 2017.
Q Can you -- when were those hospitalizations?
A The first was from March 22nd, 2017, through May 4th of 2017; and the second, September 15th, 2017, through November 13th, 2017.
Q Prior to her two 2017 state hospitalizations, was she receiving community-based services?

A She was.
Q What services were those?
A She was receiving services at the center that included psychosocial rehabilitation. She was, again, participating in groups that were under psychosocial rehabilitation. She was seeing the doctor for medication, assessment and evaluation. And I believe she was seeing the nurse for administration of medication. There is also documentation that she received community support services.
Q What are community support services?
A Community support services are an array of services that largely are provided by an individual who goes out and may meet with a person in the home, may evaluate what their needs are. There may be some direct provision of services, but largely this individual is evaluating and perhaps referring out evaluation of the individual's stability and whether there is a need for additional services, evaluation of the efficacy of the services that are being provided. It's an array of service and I can't say that I can remember all that is included under --
Q This is not a memory test.
A Okay.
Q That will do. Thank you. How often was she seeing her community support specialist, roughly?
A It varied, but my recollection is that during 2016 and portions of 2017, she was seeing the community support

specialist at least monthly.
Q What led to her March 2017 admission?
A Prior to admission, she was described as experiencing symptoms of her diagnosed mental illness, which was paranoid schizophrenia, that she was having mood swings, rapid mood swings, and that she was exhibiting violent and aggressive behavior.
Q How did her symptoms progress leading up to the point of admission? Do you want a different question?
A Perhaps a repetition of that question.
Q How did her symptoms progress leading up to her March 2017 admission?
A Oh, she continued to exhibit symptoms that resulted in her going into, I believe, Alliance, a local hospital, and ultimately being committed to the State Hospital.
Q How did Region 7 respond to her increasing symptoms?
A There is indication that the community support specialist, once aware of the change or reoccurrence or worsening of her symptoms, arranged for a precommitment evaluation and assisted with the paperwork that ultimately led to the commitment.
Q What response would you expect to see from a community mental health service provider to a developing crisis like person 18 was experiencing?
A I would expect to see assertive aggressive effort to divert from admission. I would expect to see an engagement of crisis,

mobile crisis services to see if we can get a doctor to come see her, evaluate her, get her back on her medication, perhaps remove her from the environment for a time in respite care, crisis residential program to see if we might stabilize her such that a commitment can be diverted.

Q What needs were resulting from her environment? What was going on in her environment?

A In the home, there -- even at the time that I interviewed her, there was conflict between this individual and her mother. And from review of her records, it appears that this conflict results in disagreement, some around medication compliance, which increases the stress, which worsens her symptoms and results in her making threatening remarks and sometimes behaving in threatening ways.

Q And you listed several responses that a community-based provider could provide as person 18's crisis was developing. Did you see the provision of those services in the case of person 18?

A I did not see the provision of those services.

Q Was there any change in the intensity of services that she received as she was approaching her March 2017 hospitalization?

A I do not recall seeing any change in the intensity of services.

Q Had she received more intensive services, is it possible she could have avoided the State Hospital admission altogether?

A It's certainly possible, yes.
Q How long did her March 2017 admission last?
A Until May. Early May.
Q And how would you describe the services that she received in May 2017 upon her discharge from East Mississippi State Hospital?
A She returned to receiving services at the center, participation in the psychosocial rehabilitation. There was indication of a continuation of the visits with the doctor as well as contact with a nurse, and a continuation of the community support services.
Q Was she connected with any additional services that she was not receiving before her March 2017 admission?
A I did not see additional services.
Q Was there any change in the intensity of the services that she was receiving when she was discharged in May of 2017?
A I am reviewing to make sure. But, no, I did not see nor document an increase in the intensity of services.
Q And what happened after she was discharged to the community to essentially what were the same services that she was receiving before she was admitted?
A Could you repeat the question, please?
Q What happened to person 18 after she was discharged back to essentially the same services that she was receiving before her commitment?

A In I guess a matter of months, the same pattern, in September of '17, worsening of symptoms, threatening and aggressive behavior that resulted in a return to the hospital in September 15th of 2017.
Q Was the intensity of the service she was receiving in the summer of 2017 sufficient to address her symptoms?
A No.
Q Again -- and her discharge which I believe you testified was in November of 2017, she was discharged again. Was she connected with any additional services at that time?
A It appears that she was reconnected with the services that she had been receiving: Psychosocial rehabilitation, the evaluation by the doc, nurse or administration. There was documentation that the community support services would resume once she returned to the community. But as I recall, that's where the notes that I had ended.
Q Was there any indication that she received any more intensive services upon her November 2017 discharge?
A No.
Q And when did you meet her?
A I met her on March 29th of 2018.
Q What services was she receiving at that point?
A Same services, the psychosocial rehabilitation, visits with the doctor, nurse for administration of medication.
Q Are those services -- I'm sorry. Are you done? I didn't

mean to cut you off. If you were done, I apologize.
A Yes.
Q Are those services sufficient to sustain her in the community?
A Those services have not been sufficient to sustain her as evidenced by the returns to the hospital under committed conditions.
Q What services do you think she is appropriate for?
A It's my opinion that she is appropriate for more intense services. Some of those services that she is receiving, if administered or provided at the appropriate intensity, may be helpful for her. But in looking at the issues with medication nonadherence and the need for more closer monitoring of her medication, when I evaluate the tendency to behave in aggressive manner, once symptoms appear, indicates the need for crisis response that can come where she is, they can come to the house when necessary to provide those services to her. And then when I look at what she identifies as important to her, the desire for employment, the desire to live in her own place, those are the kinds of things that more intense services such as PACT could assist her with.
Q Now, you recommended PACT for her in your report. Why PACT?
A Based on the strengths of that delivery model and being able to not just rely on her going to the center on a daily or

weekly basis to receive services, but services being brought to her and provided to her directly in the home, in the community. Based on the match between here is someone who has a serious mental illness who has had repeated hospitalizations, who has identified the need for assistance with employment, who I identified the need for assistance with crisis management and mental health therapy to assist with sorting out the sources of conflict that occur in the home.

Q I guess I'm wondering, how is PACT different from what she was already receiving?

A It's different in the intensity of the services. It's different in the range of services that can be provided directly in the community.

Q How would having received more intensive services in 2016 have affected her need for PACT services in 2018?

A Certainly, I would hope that receiving -- and certainly, I know from experience that receiving appropriate services, the earlier an individual begins to receive the appropriate services, the -- it doesn't completely eliminate but it certainly lessens the likelihood for inpatient services.

Q How does it impact the need for greater services? Let me ask it this way. If person 18 had received community support services with sufficient intensity in 2016 as her crisis was developing, would she be less likely to need a more intensive service like PACT in 2018?

A I would certainly think so. If I'm understanding the question correctly, yes.
Q And you testified that person 18 is in Region 7. You have already testified to this but, again, is PACT available in Region 7?
A At the time that I saw her, PACT was not available in Region 7.
Q You also recommended permanent supported housing in your report as provided in Mississippi through the CHOICE program in which the court has already heard testimony on. How would permanent supported housing help person 18 manage her mental illness and avoid rehospitalization?
A For this individual, in reviewing the information, it appears that the stress related to the interpersonal conflicts that occur in the home, and primarily with her mother, is a source of stress/distress for her, resulting in a worsening of symptoms of her illness and acting-out behavior. She indicates, and I believe the data supported, that there had been a time when she lived in her own place. If she was able to receive the permanent supported housing type services where she is not in the day-to-day environment where she is experiencing the conflict, it's going to certainly improve her -- it's going to improve her mood. It's going to potentially improve her perceptions of her ability to be successful and take care of herself.

Q Is person 18 at serious risk of hospitalization absent the services that you have identified?
A Yes, I think so.
Q Why?
A For the very same reasons that she has had hospitalizations in the past: A reoccurrence of symptoms, stressful situations that result in worsening of the symptoms, acting out or aggressive behavior that results in a commitment.
Q We have been focusing on the limited intensity of the services person 18 has received. For the people in your review, how does person 18's experience compare?
A Very similar.
Q So now we have discussed transition planning and service intensity, and I want to turn to my last topic which is the impact hospitalization has on the lives of the people of your review. What effect does prolonged or repeated hospitalizations have on a person's ability to care for themselves?
A We talk about institutionalization where an individual begins to lose those skills that are important in maintaining independence and maintaining functioning in the community. When someone is in the hospital for prolonged periods of time or when there are repeated admissions to the hospital setting, it certainly has the potential, I won't say it always but it certainly has the potential for compromising those skills,

those abilities that the individual has to effectively function in the community.

Q Were you present for the testimony of HB this morning?

A I was.

Q Is his daughter person 25 in your review?

A Yes.

Q Let's discuss person 25 for a minute. You begin discussing her on page 108 of your report, Plaintiff's Exhibit 408.

A Yes.

Q Can you just give us a brief description of person 25?

A Yes. Person 25 at the time that I saw her, 51-year-old Caucasian female who was at that time in the hospital. She expressed her desire to return to the community and live as independently as she could with supports. She expressed an interest in working and had, as I think he mentioned, some of the artwork with her and expressed an interest in pursuing education and further developing her artistic skills and ultimately a desire for employment in an area that she could utilize the art skills.

Q Where did you meet her?

A I met her at Mississippi State Hospital.

Q And how long had she been there when you met her?

A She had been there since 2014, January 30th of 2014.

Q And did you interview HB as part of your review in this report?

A Yes, I did.
Q Prior to her 2014 hospitalization, was she receiving appropriate community-based services?
A No, she was not.
Q And HB testified this morning about symptoms person 25 presented leading up to her 2014 admission. Are there community-based services that can address those symptoms?
A Yes. As I recall, I'm not recalling all of the symptoms he spoke of. I know the symptoms that were identified in her records. And, yes, in my opinion, there are community-based --
THE COURT: Your mic went out.
THE WITNESS: It did?
THE COURT: Okay.
THE WITNESS: It seems to be back.
THE COURT: Can you repeat?
BY MR. CASTILLO:
Q I have a feed. I'm going to read what you had said where you dropped off. "As I recall, I am not recalling all of the symptoms you spoke of. I know the symptoms that were identified in her records. And, yes, in my opinion -- I can just repeat the question.
THE WITNESS: If I can pick up from there, that would be fine for me.
THE COURT: Okay.
A In my opinion, there are community-based services available

to address what was identified as mood swings, temper tantrums, threats of self-harm. Those were the behaviors that I saw and, yes, there are community-based services that could address those symptoms.

BY MR. CASTILLO:

Q And had she received those services, those community-based services, might she have avoided the hospitalization?

A Certainly it's my opinion that the hospitalization might have been avoided.

Q Can someone with her needs live safely in community settings with appropriate community-based services?

A Yes.

Q What services would she need to live in a community?

A I identified for -- let me make sure that I'm in the right spot -- for this individual, community-based services, recommending residential placement for her where there would be supervision, 24/7 supervision. I also recommended -- I spelled out transition services. Transition service would, of course, be a part of services provided by PACT. I recommended PACT for the transition services, for the mental health therapy, for assistance with supported employment, for assistance with managing crisis situations when they occur, assistance with medication monitoring and medication management, and again for therapy focused on her history of substance use disorder as well as a history of trauma for her.

Q Would those services also help her -- strike. Let me ask it again a different way.

How would those services approach her goals that she identified as well, including the art that you discussed?

A Yeah, those are the kinds of services, supported employment, the assistance with psychosocial rehabilitation and activities of daily living, assistance, case management kinds of assistance with connecting her with resources for furthering her education. They're the kinds of services that would certainly be consistent with her expressed interests and needs.

Q In general, did you find that people in your view wanted to be in a State Hospital?

A No, I did not.

Q How does that compare to your professional experience?

A That is consistent with my professional experience.

Q Well, let's use person 1 as an example. Can you give me a brief introduction about who he is? And if you need it, your discussion of person 1 begins on page 9 of Plaintiff's Exhibit 408.

A Okay. Person 1 was 25 years old at the time that I saw him, a single Caucasian male who lived with his mom, reported having graduated from high school, talked about his desire -- while he was receiving disability, his desire to get a job and get off of disability, felt like he could certainly make more money working than he was receiving, expressed his love of

music and his love of gardening.
Q What is his State Hospital commitment history?
A He had had three admissions to South Mississippi State Hospital, and the more recent State Hospital admission was to East Mississippi State Hospital in 2017.
Q How did person 1 describe his experience at South Mississippi State Hospital?
A Referring to my report, he described South Mississippi State Hospital as a joke. He reported attending treatment team meetings and described it as they do these things called treatment team once a week. You go into a little room. You almost feel they're laughing at you. When asked about discharge planning, he stated that discharge planning feels helpless, that you don't know how you're doing, and talked about that you know that you're maybe getting close because they take the paper bag and they put your name on it and they begin to fill the bag with your clothes and your belongings and then tell you that you're about to be discharged.
His, I guess, final statement in this area was that, "I hate to say that it's worse than jail but it's worse than jail."
Q How was his subsequent commitment to East Mississippi State Hospital?
A I'm sorry?
Q How did he describe his subsequent commitment to East

Mississippi State Hospital?
A He basically said that at East Mississippi State Hospital that the food was terrible but at least they get you outside, at least you get to go outside.
Q And speaking of jail, were any of the people in your review sitting in jail with nothing more than a civil commitment order?
A There were five people for whom that was the case for their most recent admission.
Q And as a clinician, what do you think about this?
A It is certainly not ideal. It certainly is not an appropriate way to begin treatment. There may be some jails that have relationships with the centers or contractual relationships to provide a minimum of mental health services. But, by and large, certainly a jail is not a place for receiving mental health treatment. And I don't know exactly, but based on my own experience, I would imagine that there aren't many jails for whom they even have the resources available to provide it.
Q Did you see anybody getting adequate mental health treatment while they were in jail in your client review?
A I did not.
Q Do prolonged stays in the State Hospital affect what people can go back to after they're discharged?
A It certainly can.

Q In what ways?
A I think of some people in the sample, and probably one person in particular, where the prolonged stay in a hospital I will say in general can affect living arrangements, can affect whether if an individual has employment. Certainly the employer may not be willing to hold a job until someone comes from a prolonged stay in a hospital. And a rental situation may not be able to hold on to a house or an apartment if this individual is going to be away without the ability to pay for maintaining the living arrangements. And in that regard and other regards, just a loss of contact with usual relationships.
Q And did you see this happening in your client review?
A I did.
Q Let's discuss person 11 briefly. Can you give us a brief sense of who she is? And if you need it, you begin discussing her on page 53 of your report.
A Person 11 is a 41-year-old African-American woman who lived alone in the family home. She has two daughters and she expressed an interest in returning to work or beginning to work. She expressed an interest in learning -- returning to school and continuing her education. She really expressed an interest after being explained about peer services in ultimately one day learning more and being trained and perhaps being able to become employed as a peer specialist, identified liking to work on the computer and the possibility of some work

that she would be able to work from home.
Q About how long was she committed to the State Hospital?
A She was in the State Hospital from November 23rd of 2016 through early February, I believe the 8th, February 8th of 2017. So a little over two months.
She was under an outpatient commitment and so her actual discharge from the commitment was not until February 28th of 2017.
Q And what impact did this State Hospital commitment have on her life?
A Well, I believe the major impact was that she lost custody of her children.
Q When you saw her, did she -- had she regained custody of her children?
A She had not.
Q Does she have an interest in regaining custody of her children?
A Oh, absolutely she does.
MR. CASTILLO: Your Honor, if I can have a minute to confer with counsel?
THE COURT: You may.
(SHORT PAUSE)
BY MR. CASTILLO:
Q Just one or two more questions. You have testified that the people you reviewed could have avoided or spent less time

in the State Hospital. What will it take to make that a reality for the people in your client review?

A It would take I think the access to and provision of appropriate and reasonable community-based services.

Q Can you elaborate? What do they need to avoid these hospitalizations or spend less time?

A They need services that are person-centered that takes into consideration what their individual and specific identified needs are, what their desires and their wishes are for their lives, and it's going to require the appropriate array and intensity of services to meet those needs.

MR. CASTILLO: Thank you. No further questions.

THE COURT: We will take our afternoon break at this time. Fifteen minutes. We will meet back up at 3:50. That's about 17 minutes. 3:50. Thank you.

(RECESS)

THE COURT: Dr. Shambley, you can return to the stand.

Any cross-examination of this witness? I just say that for the record, Mr. Shelson. You're not being rushed at all if you need to get your notes together.

MR. SHELSON: Thank you, Your Honor.

(SHORT PAUSE)

MR. SHELSON: May I proceed, Your Honor?

THE COURT: Yes, you may.

CROSS-EXAMINATION

BY MR. SHELSON:
Q Good afternoon, Dr. Bell-Shambley.
A Good afternoon.
Q When you interviewed the people that you interviewed in Mississippi, did each interview last about an hour?
A Most of the interviews lasted for longer than an hour. I would say between an hour and a half to two hours.
Q Okay. And was each interview in 2018?
A Yes, sir.
Q And you reviewed a total of 26 individuals?
A Yes.
Q And your findings of the 26 individuals are based on your interviews, your review of the records, and your training and experience?
A As well as interviews with family members where they were available, as well as interviews with some of the personnel from community mental health centers.
Q When you said that the interviews took an hour to two hours, did that include interviewing the family members?
A For some, it did. For some, it did not, because some of the family interviews were conducted at a different time and some over the phone.
Q When individuals told you something during your interviews, what did you do to verify it?
A Where relevant, I looked for consistency between what I was

told and information obtained from record reviews and from other sources.

Q Let's talk about person 11, please. Person 11 starts on page 53 of 124.

A Yes, I'm there.

Q Do you remember talking about this person? In the highlighted part, "She said her mother and sister have legal custody of them now." And that's referring to person 11's children?

A Yes.

Q Is that correct?

A That's correct.

Q Does -- did you get that -- you got that from person 11?

A I got that from person 11 as well as from her mother.

Q And legal custody, does that indicate to you that there was court involvement in that?

A Yes.

Q Have you seen the court order or anything to do with that court proceeding?

A No, I have not.

Q All right. Do you know if there are anything that the court found in addition to what you were told by person 11 and her mother?

A I do not.

Q Did person 11's mother indicate to you that she had a

problem with that custodial arrangement?
A I don't recall her indicating a problem with the arrangement.
Q Did person 11's mother indicate to you that she thought the custody of the children should be returned to person 11?
A I recall her expressing that she was hopeful that at some point custody would be returned.
Q And did she indicate to you that at the time you interviewed person 11 and her mother that that was an appropriate time to return custody to person 11?
A That was not addressed. No.
Q How many children does person 11 have?
A She has two daughters that I'm aware of.
Q How old are they?
A At the time that I saw her, their ages were identified as 18 and 11.
Q And they were -- at the time they were living with person 11's mother?
A They were living with her mother and her sister.
Q What is person 11's diagnoses -- diagnosis?
A She had diagnoses of schizophrenia or schizophreniform, undifferentiated, schizophrenia spectrum disorder, other psychotic disorders.
THE COURT REPORTER: I'm sorry?
THE WITNESS: Yes. I'm sorry. I'm so sorry.

A Her diagnosis --

THE COURT: Make sure your microphone is on.

A She was given provisional diagnosis of unspecified schizophrenia spectrum and other psychotic disorder.

BY MR. SHELSON:

Q And what is the schizophrenia spectrum disorder?

A It is a disorder of thought, described as a serious mental illness where individuals may experience symptoms of auditory hallucinations or visual hallucinations or delusional or believe things that are not true.

Q You found that the individuals you interviewed in Mississippi, that 100 percent of them were not opposed to living in the community?

A Yes.

Q All right. And did you testify that that finding did not surprise you?

A I did.

Q And why did that finding not surprise you?

A It didn't surprise me because in my years of working with individual who have mental illness of varying ranges, I have not encountered anyone who had a desire to receive services in a hospital or in a restrictive setting if those services were available to them in the community.

Q And does that include your experience with individuals who were hospitalized in a state hospital in Alabama?

A Yes.
Q Do many adults with SMI think they have no mental illness at all?
A I'm not able to answer about "many." Are there some who would deny having a mental illness? Yes. But I can't attribute a percentage or a number to that.
Q So does it surprise you that adults with SMI who are hospitalized think they should never have been hospitalized?
A If you could repeat that once more, please?
Q I will ask it differently. Let's talk about person 1. This is on page 10 of 124 of your report. Remember this, that person 1 described South Mississippi State Hospital as a joke and that it was worse than jail?
A Yes.
Q When people say that about state hospitals, does it surprise you?
A It doesn't surprise me.
Q Let's talk about your experience with the Alabama Department of Mental Health. Can we refer to the Alabama Department of Mental Health as the ADMH?
A Yes.
Q Okay. And did you work for the ADMH for approximately 31 years, from 1985 to 2016?
A Yes, I did.
Q And did you retire on October 1st, 2016?

A Yes. I did.
Q All right. Were you a senior staff psychologist at the Taylor Hardin Secure Medical Facility from 1985 through 1988?
A Yes.
Q What is that facility?
A That is the forensic facility for the State.
Q Were you the director of psychological assessment services at Bryce Hospital 1988 to 1989?
A Yes.
Q And what is Bryce Hospital?
A Bryce Hospital is a civil commitment hospital operated by the Department of Mental Health.
Q And were you then the director of neuropsychology service at Bryce Hospital from 1989 through 1994?
A Yes.
Q So you were out -- you were at Bryce Hospital for a period of about six years?
A That's right.
Q When you were at Bryce Hospital, did you treat adults with SMI?
A I provided psychological evaluations and neuropsychological evaluations on individuals at Bryce Hospital, yes.
Q When you were at Bryce Hospital, was it the most integrated setting appropriate to the needs of the patients you treated?
A No.

Q And why do you say no?
A I think of an integrated setting being a setting where an individual has the opportunity to live and interact with individuals who do not have a mental illness, and the only persons that a consumer would interact with at Bryce Hospital would be staff persons, so I don't think of a hospital as being an integrated setting at all.
Q Was it the least restrictive setting according to their needs at the time?
A Given that individuals were there under a civil commitment order, that determination had been made, yes.
Q When you were at Bryce Hospital, were the individuals there appropriate for and would benefit from community-based services?
A Yes.
Q Do you know of anyone who would not benefit from community-based services?
A I can't think of anyone who would not benefit from community-based services in the general sense.
Q Can you think of anyone who would not be appropriate for community-based services?
A I think that there are times when, again, based on the symptom presentation and behaviors, that an individual might not be appropriate for community-based services at a specific time.

Q What are such times?
A That would vary depending on the individual. I think in terms of persons who are persistently aggressive towards others, and I don't mean every now and then but persistently exhibiting aggressive behavior that might not be able to be managed in a community setting, individuals who have an extensive history of behavior such as fire setting, but those are not the typical -- typical behaviors, but that --
Q In your experience in the state hospitals of Alabama, how often were people who were admitted fall into just those two categories?
A I'm not able to say.
Q Do you agree that the majority of people who you came in contact with in the state hospitals in Alabama did not fall into those two categories?
A Did not fall into those two categories.
Q Okay. Were you the Facility Director 1 at the Mary Starke Harper Geriatric Psychiatric Center from 2003 through 2007?
A Yes.
Q And what is that facility?
A It's an acute care or psychiatric hospital for individuals 65 and over.
Q What are the admission criteria for that facility?
A Aside from the age requirement, it would be the commitment criteria of having serious mental illness, danger to self or

others, and the presence of an illness that, absent treatment, could worsen.

Q In your experience, people 65 and older with serious mental illness, can it be difficult to find placements for them in the community?

A It can be.

Q So what is the purpose of a facility like Mary Starke Harper Geriatric Psychiatric Center?

A The purpose of the Harper Center was to provide short-term acute care services to stabilize and return the geriatric population either to home or community nursing homes or the environment that they came from.

Q When you were at that facility, was it the least restrictive setting for the people who were admitted to it?

A In all cases, no. If I'm understanding your question, was it the least restrictive, no.

Q Then why were they there?

A Because they were under a commitment.

Q A commitment from a court?

A A commitment from a court.

Q So it's your view that in those instances, the courts just made a mistake?

A In some cases, yes.

Q And what did you do about it?

A Our responsibility was if there was someone there who did

not need to be there, to initiate plans for expediting discharge.
Q And if a court in Mississippi mistakenly sent someone to a state hospital in Mississippi, is that what you would expect a state hospital in Mississippi to do?
A I can't say that I formulated any opinions about what the State of Mississippi should do.
Q Were you the associate commissioner of mental health and substance abuse services division from July 2012 through September 2016?
A Yes.
Q And was that the position you held with ADMH until you retired?
A Yes.
Q When you became -- I'm just going to say associate commissioner from now on. Would that be okay?
A That's fine.
Q Thank you. When you became associate commissioner in July 2012, did Alabama have six state hospitals?
A Yes.
Q Were they Bryce Hospital, Taylor Hardin Secure Medical Facility, Mary Starke Harper Center, Searcy Hospital, Greil Hospital, and North Alabama Regional Hospital?
A Yes.
Q And in 2012, did Searcy and Greil close?

A Yes.
Q And in 2015, did North Alabama Regional Hospital close?
A Yes.
Q So when you retired in October 2016, Alabama still had three state hospitals that were open?
A Yes. That's correct.
Q Okay. And they were the ones we've talked about earlier, correct, Bryce Hospital, Taylor Hardin, and Mary Starke?
A Yes.
Q Does Alabama have regional community mental health centers?
A Yes.
Q Does Alabama deliver its community-based services through those community mental health centers?
A And other providers. But, yes, through the community mental health centers and other community hospitals and other providers, yes.
Q Did Alabama have 24 regions when you retired?
A That sounds right, yes.
Q And do the CMHCs -- CMHCs, community mental health centers -- do the CMHCs in Alabama cover certain counties?
A Yes.
Q And are the CMHCs in Alabama operated by the counties?
A The CMHCs are operated by the -- a board of directors, a 310 boards that are local boards.
Q Right. So the boards are not Alabama Department of Mental

Health individuals?
A No. No.
Q And then does the ADMH certify the CMHCs in Alabama?
A Yes.
Q And does ADMH provide funding to the CMHCs?
A Yes.
Q And generally speaking, what form does that funding take?
A By contract, funding is primarily state dollars. I'm not sure that --
Q Is it generally by state grants or state contract or what?
A By contract.
Q But it's -- by contract, ADMH pays state dollars to the CMHCs?
A If I'm understanding the question correctly, yes.
Q Okay.
A Yes.
Q Is the structure of CMHCs in Mississippi similar to the structure of CMHCs in Alabama?
A I don't know enough about the structure of the CMHCs in Mississippi to render an opinion.
Q Do you recall in your deposition if you testified that the structure is similar?
A Yeah, I probably did. The rest of what I was going to say was I don't have any reason to believe that they aren't, but I simply did not engage in a study or analysis of the CMHCs in

Mississippi.
Q When you were the associate commissioner, what percentage of the patients in Alabama's state hospitals were opposed to receiving community-based services?
A I -- I have no idea.
Q When you were the associate commissioner, do you know what percentage of the patients in Alabama state hospitals were appropriate for or would have benefited from community-based services?
A No, I can't say that I have that information available to me.
Q When you were the associate commissioner, were any patients sent to jail in Alabama on nothing but a civil commitment order immediately before going to an Alabama state hospital?
A I don't know specific cases. I certainly imagine that there were.
Q Do jails in Alabama have the resources to address mental health issues?
A I have not -- I don't have that information available to me. From my own experience, I know that some do, but most do not.
Q And to your knowledge, is that a nationwide problem?
A Again, I can't say that I have done the research or analysis to know exactly, but reason tells me that yes.
Q To your knowledge, is lack of resources to address mental

health issues also an issue in the federal prison system?
A I'm not able to speak to that.
Q In Alabama, excluding forensic patients, are all commitments to state hospitals involuntary commitments pursuant to a court order?
A Yes.
Q In Alabama, is a standard for commitment to a state hospital danger to self or others?
A Along with the other.
Q Well, is that one of the criterion?
A Yes.
Q Are there other criteria?
A Yes.
Q What are they?
A The presence of a mental illness.
Q And any others?
A You've mentioned the danger to self or other. The -- that treatment is available and, absent treatment, the person would be reasonably expected to continue to decline.
Q As you downsize state hospitals, should you increase community-based services?
A If the question is in relation to what happened in Alabama?
Q It's not, so let me -- in general, do you agree that as you downsize state hospitals, you should increase community-based services?

MR. CASTILLO: Objection, Your Honor. Dr. Bell-Shambley is not here as a systems expert. She is doing a client -- it's outside the scope --

THE COURT REPORTER: I'm sorry?

THE COURT: Make sure you're speaking into the microphone.

MR. CASTILLO: It is outside the scope of her testimony and her work in this case.

THE COURT: Okay. I'm going to overrule the objection. She can answer if she can.

BY MR. SHELSON:

Q Do you need the question again?

A Yes, please.

Q Okay. In general, do you believe as you downsize state hospitals, you should increase community-based services?

A Yes.

Q As associate commissioner, did you oversee a state hospital psychiatric transformation?

A Yes, I oversaw the transformation of hospitals within the system.

Q As part of that process that you were involved in, did ADMH give the community mental health centers the responsibility for developing the plans and services that would be needed once the hospitals closed?

A Yes.

Q And when you were involved in that process, were the two regions in Alabama that were impacted by the hospital closings Regions 2 and 4?
A There -- no.
Q What were the regions impacted?
A Well, the planning for the downsizing, there may be reference -- well, answer the question I'm asked. To downsizing efforts that included 2 and 4, the planning for the closure of the hospitals was actually statewide, and the potential for impact on all of the regions within the state, because there were some statewide shared services.
Q Yeah. Okay. Where is Region 2?
A Region 2 is Birmingham, Tuscaloosa, kind of central north part of the state.
Q Where is Region 4?
A Region 4 is southern part of the state.
Q On the coast?
A On the coast, as well as kind of across the Washington counties.
Q Do you believe ADMH acted reasonably in having the CMHCs identify the services they believe were needed in that process?
A Acted reasonably?
Q Yes.
A Yes.
Q Why did you believe that was a good approach?

A The centers, the community mental health centers, again, and additional community providers, the Department of Mental Health does not provide direct community-based services. We rely on our partners with the community mental health centers as well as other community providers.

THE COURT REPORTER: I'm sorry?

THE WITNESS: I'm so sorry. I'm sorry.

A Direct services in the community. And so we relied on the individuals who were the experts in the provision of direct community services to develop plans to say what additional services or expansion or augmentation of existing services were needed.

BY MR. SHELSON:

Q Does the continuum of mental health care include both community-based services and state hospitals?

A The continuum in Alabama?

Q Do you know what -- are you familiar with the term "continuum of care" in the mental health field?

A Yes, I am.

Q What does that mean to you?

A It means an array of services across different service environments where an individual is able to receive services and as step-wise or progression may move from one level of the continuum to the next, hopefully in the direction from more restrictive to less restrictive.

Q My question is this: In the mental health field, does a continuum of care include both community-based services and state hospitals?
A Yes.
Q All right. You reviewed 25 individuals in Mississippi who were living at the time?
A Yes.
Q And at the time of your review, four of those 25 were in a State Hospital?
A That's correct.
Q So at the time of the interviews, 21 of the 25 were in the community. Is that correct?
A That's correct.
Q And did you also find that 19 of the 25 individuals you reviewed were appropriate for PACT?
A If I may get to that part of the report?
Q Sure.
A Yes.
Q Okay. And I'll represent to you that 19 of 25 is 76 percent. To your knowledge, is there any state that provides PACT services to 76 percent of the people it discharges from its state hospitals?
A I don't know.
Q When you were with the ADMH, did Alabama provide PACT services to 76 percent of the individuals it discharged from

its state hospitals?
A No.
Q Do you know what percentage of individuals it provided PACT services to who were discharged from its state hospitals?
A I do not.
Q Do you know how many PACT teams Mississippi would need to be able to provide PACT services to 76 percent of the people it discharges from its state hospitals?
A No, I do not.
Q Do you know how much it would cost to provide that quantity of PACT teams?
A No, I do not.
Q Has Alabama made any modifications to its PACT model for rural areas?
A Yes.
Q Have those modifications included reducing the number of staff on rural PACT teams?
A Yes.
Q Were those staffing modifications made because it's difficult to recruit staff for rural areas?
A The modifications were made for that reason as well as the level of individuals in rural areas needing the service, so yes.
Q In Alabama, are the PACT teams operated by the CMHCs?
A Yes.

Q In Alabama, does funding for PACT include both state funds and Medicaid funds?
A Yes.
Q Doctor, this is on page 6 of your report.
A Okay.
Q And I'm going to ask you about this paragraph here. It's the third from the bottom. Did you find that all 25 individuals could benefit from mobile crisis service or crisis residential services?
A Yes.
Q Obviously, that's 100 percent of the individuals. Is that correct?
A That's correct.
Q Do you know how many mobile crisis teams Mississippi would need to provide mobile crisis services or crisis residential services to 100 percent of the people it discharges from its state --
A No, that was outside of the scope of my work to --
Q Do you know how much it would cost to provide that quantity of mobile crisis or crisis residential services to that in Mississippi?
A I do not.
Q We discussed earlier that three state hospitals in Alabama were closed during the 2012 to 2015 time frame. Do you recall that?

A Yes.
Q Do you know what percentage of the people who were discharged when those hospitals were closed received mobile crisis or crisis residential services?
A I do not -- I do not know. I don't have --
Q Do you know what --
A -- recall.
MR. SHELSON: I'm sorry.
BY MR. SHELSON:
Q Do you know what percentage of them received PACT services?
A I do not.
Q Based on your experience in Alabama, is it realistic to fund mobile crisis services or crisis residential services for 100 percent of the people discharged from state hospitals?
A I'm thinking to understand the question. Could you repeat the question again, please?
Q Yes, ma'am. Based on your experience in Alabama, is it realistic to fund mobile crisis or crisis residential services for 100 percent of the people discharged from state hospitals?
A I guess the question to me sounds as though there is an assumption that 100 percent of the people would be in need of this service, and I don't think that's an accurate assumption, so --
Q If the assumption were accurate, would it be realistic to fund those services in that quantity?

A Realistic in terms of the actual resources to do that?
Q Yes, ma'am.
A I don't think so.
Q Based on your experience in Alabama, is it realistic to fund PACT services for 76 percent of the people discharged from state hospitals?
A I can't answer that without --
Q Without what?
A Without additional information.
Q Such as what?
A Such as data to suggest or to evaluate whether indeed what is the percentage of the people as we did when we were looking at closure and downsizing of the hospitals and the individual assessments of what individuals needed.
Q Did you find that 76 percent of the individuals you reviewed in Mississippi could benefit from mental health therapy? This is also on page 6 of your report.
A Yes.
Q Okay. Do you know what Mississippi would have to do to provide mental health therapy to 76 percent of the people discharged from its state hospitals?
A I'm sorry. I believe the number is 96 percent for mental health therapy.
Q You're correct, and I'm wrong. Do you know what Mississippi would have to do to provide mental health therapy

to 96 percent of the people it discharges from its state hospitals?
A I do not.
Q Do you know how much it would cost to do that?
A I do not.
Q Now, this number -- do you have Exhibit 408.A in your binder?
A I do.
Q And that's an addendum to your report?
A Yes.
Q In what percentage of the individuals that you reviewed in Mississippi did you find needed permanent supported housing?
A I found that 12 individuals in my sample, 48 percent, needed permanent supported housing.
Q Do you know what Mississippi would have to do to provide permanent supported housing to 48 percent of the people it discharges from its state hospitals?
A No, I don't.
Q Do you know how much it would cost to do that?
A I do not.
Q And then sticking with Exhibit P-408A, what percentage of individuals did you find were appropriate for and would benefit from substance use disorder treatment?
A I found that 18 of the 25, 72 percent, would benefit from substance use disorder treatment.

Q Do you know what Mississippi would have to do to provide substance use disorder treatment to 72 percent of the individuals it discharges from its state hospitals?
A No.
Q Do you know how much it would cost to do so?
A I do not.
Q Would you look at page 7 of your report, please.
A Yes.
Q And it starts on 7. I'm looking at the last bullet point on page 7. Does it read, "Concern about the adequacy of a recovery-oriented environment in personal care homes. It is unclear whether the responsible State entities are monitoring compliance with applicable standards and taking remedial action when PCH providers are out of compliance"?
A I see that, yes.
Q Did you find any instance where a PCH provider was out of compliance in Mississippi?
A I did not evaluate the personal care homes for compliance. So, no, that was not a part of my work.
Q With respect to the 26 individuals you reviewed, did you find any instances where an individual was receiving a dose of medication that you objected to?
A Again, that was outside of the scope of my work to make decisions regarding the dosage of medications.
Q In your experience, are there instances where a patient can

be prescribed more than one antipsychotic medication at a time?
A There are instances where the prescriber is, according to standards of care and practice, if an individual is going to be prescribed more than one class of medications or antipsychotic medications, that they are expected to justify the rationale for that and with appropriate justifications.
Q With appropriate justifications, that's an acceptable practice?
A Yes.
Q Doctor, would you turn to page 23 of 154 of your report and person 4?
A Yes.
Q I'm sorry I hesitated, because part of what I was going to have you read or show you is redacted. But, anyway, all right. This is again page 23 of 124.
A Uh-huh.
Q And I'm here at the sentence. At the time you interviewed person 4, was he living independently in an apartment in the community?
A Yes.
Q And did you find that person 4 is at serious risk of institutionalization?
A I did.
Q This is page 25 of 124 of your report, still on person 4. The highlighted sentence, does it read, "Person lives

independently in his own apartment, receives SSI, and manages his own funds"?
A Yes.
Q If we could turn to person 23 on page 100 of 124?
A Yes.
Q Okay. Are you ready?
A Uh-huh.
Q When you interviewed person 23, was he living independently in his home in the community?
A Yes.
Q When you interviewed person 23, he was not having any problems with his medication, was he?
A No.
Q When you interviewed person 23, was he doing well living independently in the community?
A Yes.
Q Did you find person 23 to be at serious risk of institutionalization?
A I did.
Q Can we turn to person 25, please? And this person starts on page 108 of 124.
A Okay.
Q I think we established in your testimony earlier that person 25 is the daughter of HB who testified this morning. Is that correct?

A Yes.
Q And person 25 is the person who was referred to as SB in court this morning?
A Yes.
Q Is that correct? During the 1980s, was person 25 hospitalized in Georgia and Alabama?
A Yes.
Q Were those state hospitals?
A I am not certain that they were state hospitals. I know some of the hospitals -- some of the records that I saw for Georgia were not state hospitals. And I believe the hospital that was referenced in Alabama was not a state hospital.
Q Are person 25's most consistent diagnoses borderline intellectual functioning and borderline personality disorder?
A Yes.
Q What is borderline intellectual functioning?
A Borderline intellectual functioning by criteria is intellectual functioning that is above 69, in the 70 to 79 range by accepted measured intellectual assessments, and individuals who may have some difficulties in judgment, in decision-making, but is not at a level that would be identified as intellectually deficient.
Q So in practical terms, how would that affect such a person's daily functioning?
A Individual may need some extra guidance, teaching, training

on activities of daily living, ADLs.
Q In 2012, was person 25 discharged from North Mississippi State Hospital to a personal care home? This is on page 108 of your report.
A Yes.
Q Okay. And did she -- was she kicked out of that personal care home? This is on page 109 of your report, the first full paragraph, second sentence.
A Yes. What's documented there is she reported that she was kicked out of the last personal care home.
Q And then does your report state that she subsequently lived in an apartment?
A Yes.
Q And did she -- the highlighted part, "She said she then moved in with three girls that she met, and according to her, she recognized this was a *bad decision*. She said her father, who is her conservator, *had me committed because I was living with bad people*."
A Yes.
Q That's what she reported to you?
A That's what she reported.
Q Is your housing recommendation, and this is page 110 of your report -- let me start over. Is your housing recommendation for person 25 a small two- to four-person residential placement with 24/7 supervision?

A Yes.
Q Why 24/7 supervision?
A Because this is an individual who is -- the recommendation -- she has been in the hospital in a restrictive environment where she has received supervision and not -- and decisions being made for her. My recommendations are based on transitioning and providing the supervision and supports with the hope that as she continues to live in the community, that the level of supervision could be decreased based on her functioning.
Q After you interviewed person 25, and still in 2018, do you know whether person 25 was discharged from Mississippi State Hospital?
A I heard this morning that she had been discharged.
Q Do you know anything about that other than what you heard this morning?
A (Shakes head in negative response.)
Q Okay. Then I will move on.
I want to refer you to page 3 of your report, and the paragraph at the top of the page, the sentence that starts here. It's the -- there we go.
A Okay.
Q It starts here. Does that read, "Under my administration, ADMH expanded community-based service capacity, particularly in the areas of supported employment and integrated housing, and

increased the number of certified peer support specialists"? Did I read that correctly?
A Yes.
Q All right. Do you hold Alabama's mental health system out as a model for Mississippi?
A No, I do not.
Q Why don't you?
A One, I recognize that there are challenges from my work in Alabama. I recognize that the system is not perfect. I certainly did a lot of work that I was proud of and some accomplishments that were I think meaningful for the lives of those individuals served, but certainly I hold that -- I don't hold that out as a model for Mississippi or any other state.
Q When you retired from ADMH in 2016, do you know how many people were receiving supported employment services?
A I do not.
Q When you retired from ADMH in 2016, do you know how many people were receiving integrated housing?
A I do not. I don't want to hazard a guess. I have certainly numbers in my head but I don't want to guess, so, no, I do not.
Q When you retired from ADMH in 2016, do you know how many certified peer support specialists Alabama had?
A I do not. I have a number, and I know we differentiated between those individuals who were certified peer specialists

and those individuals who were employed as certified peer specialists, and I know the number of individuals that were certified as peer specialists was significantly greater than the numbers who were actually being employed in the community mental health centers or in various capacities.

Q Just a couple more questions along this line and then I will move on. When you retired from ADMH in 2016, do you know how many PACT teams Alabama had?

A At that time, there were I believe two full fidelity PACT teams.

Q So not every region in Alabama had a PACT team?

A Not every region had full fidelity PACT teams.

Q Were you finished?

A I was about to say that the regions had -- that, as we talked about earlier, modified teams, the ACT teams and in-home teams.

Q Do other regions in Alabama have one or the other, either a full fidelity PACT team or a modified PACT team?

A Yes, I believe so.

Q Are you sure about that?

A I'm not sure about that.

Q When you retired from ADMH in 2016, do you know how many mobile crisis teams Alabama had?

A No. No, I do not. I can't remember. I don't have -- the information certainly was available to me, but I can't recall.

Q When you retired from ADMH in 2016, do you know how many crisis stabilization unit beds Alabama had?
A I don't recall.
Q When you retired from ADMH in 2016, did Alabama have a strategic plan, Alabama DMH?
A Have a strategic plan for --
Q Did the Alabama Department of Mental Health have a strategic plan?
A Yes.
Q Did it have an *Olmstead* plan?
A There was an *Olmstead* plan that was dated and had not been updated. That's my recollection of the *Olmstead* plan that was in existence.
Q When you say it was dated, do you --
A Old.
Q Yeah. How old?
A I don't recall.
Q Was it a functioning plan at the time?
A It was a plan that was -- much discussion occurred regarding pulling together a group of individuals to work on updating that plan.
Q That was in process when you retired?
A Yes.
Q Okay. Are there any unmet needs for adults with SMI in Alabama?

A Certainly there are.
Q Are there unmet needs for adults with SMI in Alabama in part because of insufficient funding for community-based services?
A Yes.
Q Are there unmet needs for adults with SMI in Alabama in part because of mental health workforce shortages in some areas?
A Most likely, yes. Again, I can't quote a specific source, but from my experience, yes.
Q Are there mental health workforce shortages that are particularly acute in rural areas of Alabama?
A Again, I can't answer that. I don't know. Logics suggest that the answer would be yes, but I don't have data to support it.
Q Do you know of any state that has no unmet needs for adults with SMI?
A I do not.
Q Are there any barriers to receiving community-based services for adults with SMI in Alabama?
A Aside from the barriers that we just discussed, such as funding of services?
Q Well, let me be specific so I can hopefully finish soon. Is transportation a barrier to adults receiving community-based services in Alabama, especially in rural areas?

A It certainly can be. I am aware of some efforts that were put in place to try and address that barrier for some parts of the state for rural areas, but certainly it can be.
Q Are there any barriers to housing for adults with SMI in Alabama?
A Yes.
Q Do those barriers include that there is not enough available affordable housing to meet the need?
A Yes.
Q In Alabama, is funding a barrier to being able to provide sufficient community-based services for adults with SMI?
A Yes.
MR. SHELSON: Your Honor, may I approach the witness?
THE COURT: Yes, you may.
BY MR. SHELSON:
Q Doctor, have you seen Exhibit D-239 before today?
A I believe I saw this exhibit during my deposition.
Q I will represent to you this was Deposition Exhibit D-2. I want to direct your attention to page 2 of D-239. That first highlighted paragraph, does it read, "Associate Mental Health Commissioner Dr. Beverly Bell-Shambley said she met with hospital staff Tuesday to announce the closure and that consumers served by the facility will transition into the community"?
A Yes.

Q Is that an accurate statement?
A Yes.
Q And then the next paragraph, does it read, "Patients will receive services from the community mental health centers. Bell-Shambley said some centers have contacts with local hospitals but they will have community healthcare in place much like they did when Greil and Searcy closed in 2012"? Is that quote accurate?
A Yes.

MR. SHELSON: Your Honor, we move to admit Exhibit D-239 into evidence.

THE COURT: Any objection from the United States?

MR. CASTILLO: Yes, Your Honor. We object on the grounds of relevance and under Rule 403.

THE COURT: Let me -- any response?

MR. SHELSON: Yes, Your Honor. In both her report and in her testimony today, Dr. Bell-Shambley talked about that while she was the associate commissioner, her involvement in the transition of the downsizing or the closing of state hospitals and transition to community-based care and, again, that's both in her report and in her testimony today, and this concerns exactly that issue.

THE COURT: I'm going to overrule the objection.

(EXHIBIT D-239 MARKED)

MR. SHELSON: Your Honor, I'm going to try to finish

up in 10 minutes.

THE COURT: Yes.

MR. SHELSON: Thank you.

BY MR. SHELSON:

Q Doctor, would you -- the next exhibit there is Exhibit D-241. Would you look at that, please?

A Yes.

Q All right. Did you see -- did we discuss Exhibit D-241 in your deposition?

A Yes, I believe you presented it to me and asked --

Q And are you familiar with AL.com?

A I am familiar with AL.com.

Q And what is that?

A Excuse me. A news source in the state of Alabama.

Q And does this indicate that this article was posted on August 17th, 2016?

A Yes.

Q All right. This first sentence here that's highlighted, "North Alabama Regional Hospital closed in June 2015, leaving only three state-run psychiatric hospitals in Alabama, all in Tuscaloosa." Is that an accurate statement?

A It is.

Q Would you -- I'm going to direct your attention to page 2 of this article and to the highlighted sentence, "The wait list for Bryce Hospital, one of three facilities still operated by

the State, peaked at almost 60 patients one day earlier this year, up from an average of less than 10 in 2012, according to the Alabama Department of Mental Health." Do you dispute that the waiting list for Bryce Hospital peaked at almost 60 one day in 2016?

A I am not able to dispute nor agree to it.

Q I'll move on then. I'm going to direct your attention to page 7 of Exhibit D-241.

A Yes.

MR. SHELSON: I'm sorry, Judge. I'm envious of not having Tim at my disposal, but I will move on.

THE COURT: Okay.

BY MR. SHELSON:

Q Does this read, "For every hospital bed closed by the State, officials transferred $60,000 of the $150,000 savings to the community mental health care system. The amount of funding for community-based services has increased but not as quickly as the decrease in funding for psychiatric hospitals." Do you agree with that statement?

MR. CASTILLO: Objection, Your Honor. The document speaks for itself, and there hasn't been any foundation for its reliability or its relevance, so we object.

THE COURT: I'm going to sustain the objection as to lack of foundation right now.

BY MR. SHELSON:

Q Would you look at Exhibit D-242, Doctor.
A Yes.
Q Have you seen this document before today?
A Likewise, I saw this document that you presented during the deposition.
Q Do you know who Jimmy Walsh is?
A I do.
Q Who is he?
A Mr. Walsh is an attorney in Alabama who at one point served as the president of the National -- the local chapter, Alabama chapter of National Alliance on Mental Illness.
Q Which is NAMI?
A NAMI, uh-huh.
Q And did you testify earlier today about that you're involved in some way with NAMI?
A With the local chapter of NAMI in Tuscaloosa.
Q And how does that relate to Mr. Walsh's involvement with NAMI? He was -- he was the -- out of the state NAMI chapter?
A Yes.
Q And you're involved with what chapter?
A My current involvement is with the local chapter in the city that I live, in Tuscaloosa.
Q Okay. And is the Tuscaloosa chapter of NAMI affiliated with the Alabama state NAMI entity?
A There is some degree of affiliation.

Q Do you agree that there is not adequate funding for Alabama's mental health system?

MR. CASTILLO: Objection, Your Honor. Asked and answered.

THE COURT: She may answer it.

A I'm sorry.

BY MR. SHELSON:

Q Do you agree that there is not adequate funding for Alabama's mental health system?

A Yes.

Q All right. Let's circle back to when you were associate commissioner. Was the plan to close state hospitals and shift funds to CMHCs to treat people in the community?

A Yes.

Q All right. You agree that the funding that was shifted to the CMHCs was not able to fund everything that was needed in the community?

A Yes, I agree.

Q If I could direct your attention to page 7 of your report which, again, is Exhibit PX-408. And I would like to direct your attention to that first bullet point under "Key Themes." Does it read that, "Inconsistencies in the availability of evidence-based practices across the state. Interviews with certain CMHCs indicated that they do not have PACT, Supported Employment, or Supported Housing. There are rural areas that

are" -- no. I will start over.

Let me just skip that. Are there inconsistencies in the availability of community-based services across Alabama?

A I'm certain that there are. I'm not able to provide specific data.

Q Are there rural areas in Alabama that are greatly in need of community-based services?

A Yes.

MR. SHELSON: May I have a moment to confer, Your Honor?

THE COURT: Yes.

(SHORT PAUSE)

BY MR. SHELSON:

Q Doctor, is there such a thing as an optimal quantity of community-based services?

A I can't address that. I have not done the research or studied to know whether there is or is not.

Q You agree that your involvement in this case did not focus on what system changes to Mississippi's mental health service system may be needed?

A It did not.

Q And so in this case you did not evaluate Mississippi's mental health service system?

A I did clinical evaluations of the 26 individuals mentioned in my report. And as a result of the findings for those

individuals, I came to some conclusions. But, no, the evaluation of Mississippi's system was not within the scope of my duties.

Q It was not within the scope of your work in this case?

A Correct.

Q Thank you, Doctor.

MR. SHELSON: Thank you, Your Honor. That's all the questions I have.

THE COURT: Mr. Castillo, any redirect?

MR. CASTILLO: Yes, Your Honor. Just briefly. And I appreciate your pronunciation.

THE COURT: All right.

REDIRECT EXAMINATION

BY MR. CASTILLO:

Q All right. Good afternoon again, Dr. Bell-Shambley.

A Good afternoon.

Q Mr. Shelson asked you about the role of the CMHCs in the Alabama -- the Department of Mental Health, ADMH, I will use it -- in the service development when Alabama downsized the state hospitals during your tenure as the associate commissioner, and I would like to ask you a few more questions about that role.

THE COURT: Keep your volume up, please.

MR. CASTILLO: Yes, sir.

THE COURT: Okay.

BY MR. CASTILLO:
Q First I want to direct you to a part of your report, page 2 of Plaintiff's Exhibit 408. And if you actually look on your screen, can you read the highlighted portions?
A My screen is blank with a blue line that says "Out of Range."
Q We will try this way.
THE COURT: There it is. It popped up. So go back and do whatever you were doing. Yeah.
THE WITNESS: It's there now.
BY MR. CASTILLO:
Q Can you please read the highlighted portions?
A Yes. "To close state psychiatric hospitals, it was vital that the community mental health system" --
THE COURT: Hold on. If you're going to read, slow down.
THE WITNESS: Thank you, Your Honor.
A "To close state psychiatric hospitals, it was vital that the community mental health system be positioned to increase its capacity and serve the influx of new consumers. It was my responsibility to bring professionals from the hospitals and community together to develop and implement a synchronized effort, one that proved critical to the system of transformation."
BY MR. CASTILLO:

Q You can keep going.
A "We were able to realign funding and resources to ensure that the needed services and resources shifted to the community and away from institutional settings."
Q And if you turn the page, there is one more portion I would like you to read.
A Okay. "The provider network was pressed to expand their cultural mindset from a medical model to a recovery model. Under my administration, ADMH expanded community-based service capacity, particularly in the areas of supported employment and integrated housing, and increased the number of certified peer support specialists."
Q Can you describe generally what ADMH did to expand community-based services as you described in your report?
A It was a collaborative effort with the community providers. And again, the community providers included the community mental health centers as well as community hospitals, as well as probate courts, local hospitals to get buy-in for the transformation that was occurring. There were at points when community providers' contracts, funding, was at risk because there was an expectation that you are going to know the people in your region or catchment area who are in the hospital and you are going to be vigilant in assuring that those individuals come out of the hospital as quickly as appropriate. And so that gave them accountability, gave us accountability for

monitoring and making sure that people transitioned to those community-based services.

There was --

Q If there is more to say, go ahead. Or if you're done, that's also fine.

A I was just going to say there was also a degree of accountability, and I certainly am not promoting that things were perfect. It's a challenge. And it required creativity and negotiations and lots of coming together to recognize that we're trying to get to this step to closure of hospitals and transitioning services, at the same time recognizing that there are other steps to come, because we don't want to transition people from the hospital and reinstitutionalize them in the community. So it was an ongoing work and work that has to continue.

But we, in my opinion, accomplished some meaningful things in those four years, things that I'm proud of.

Q And you mentioned some of those earlier in your testimony today. You also note here that the provider network was pressed to expand their cultural mindset. What do you mean by that? I'm sorry. Can you just explain what you meant by that?

A To provide training to staff on a recovery-oriented system of care, to -- I can't speak for -- at one time during my tenure, there was a requirement that the centers hired peer specialists to work in their system of care to assist people

with transitioning to the community, to provide training. So those kinds of things.
Q What was ADMH ultimately responsible for in the oversight of the community-based services? Or, sorry. Let me ask this a different way. Was ADMH ultimately responsible for the oversight of the community-based services?
A ADMH's responsibility was ultimately oversight, to a large degree, funding, as well as certification of those community providers.
Q Was ADMH ultimately responsible for ensuring the availability of community-based services?
A I would say the responsibility of assuring the availability of community-based services was with the community mental health centers with the understanding that it was also a part of ADMH's certification requirements, that --
Q Is there any more?
A I guess to answer your question more directly, yes, ADMH ultimately was responsible for assuring appropriate services were available.
Q And why is it important that ADMH, the state agency, retain ultimate responsibility in ensuring the availability of community-based services?
A By law, it is the Department of Mental Health's responsibility for assuring there is a cohesive provision of services for individuals with mental illness, with substance

abuse disorders, substance use disorders, as well as intellectual deficiency. So by law, the Department of Mental Health is entrusted with the responsibility of assuring that those services are available.

MR. CASTILLO: If I can get one minute to confer?

(SHORT PAUSE)

MR. CASTILLO: Maybe one second. No more questions.

THE COURT: Believe it or not, I have no questions for this witness.

Dr. Bell-Shambley, let me make sure the record is correct. D-239 was not admitted into evidence. Correct?

THE CLERK: Yes, it was.

THE COURT: It's admitted? D-239 is admitted. D-241 was not, and D-242 was only referred to and was not moved for admission. Is that correct?

MR. SHELSON: That is correct.

MR. CASTILLO: That is our understanding as well, Your Honor.

THE COURT: All right. You may step down, Dr. Shambley.

Is she finally excused?

MR. CASTILLO: She is excused.

THE COURT: All right. You may go about whatever duties you have left for today.

THE WITNESS: Dance a jig.

THE COURT: Dance a jig? If you're staying in Jackson overnight, spend some money here. That's all we ask.

All right. This concludes the testimony for today. I'm not going to turn to Ms. Rush and find out how we are going to do tomorrow.

MS. RUSH: Your Honor, given my prediction this morning, I understand.

THE COURT: That's fine. That's fine. We are all here to have as good of a time as we can. But let me ask you this. If your notes -- I'm looking at my notes that I have been taking. PX-1095 was yesterday's testimony with Byrne, B-Y-R-N-E. What does your record show, Ms. Summers? PX-1095.

THE CLERK: I have it as admitted.

THE COURT: You don't have to check now but that's one that I was not sure of based on my notes.

MR. SHELSON: It's in the binder, Your Honor, and I think they offered it and I know we didn't object to anything offered yesterday.

THE COURT: Okay. All right.

All right, then. We will start up tomorrow morning at 9:00 a.m. On Thursday morning we won't start until 9:30, I think. It might be 9:30, 9:45 before we can start. I believe I have a criminal matter that I have to take care of before we start on Thursday morning. So I just tell you that so you can plan for it. And that's all we have today. Thank you so much.

Oh, I'm sorry. Is there anything we need to take care of?

MS. RUSH: Nothing else from the United States. Thank you.

THE COURT: All right.

MR. SHELSON: No, Your Honor.

THE COURT: All right. We will see everybody tomorrow morning at 9:00.

CERTIFICATE OF REPORTER

I, BRENDA D. WOLVERTON, Official Court Reporter, United States District Court, Southern District of Mississippi, do hereby certify that the above and foregoing pages contain a full, true and correct transcript of the proceedings had in the aforenamed case at the time and place indicated, which proceedings were recorded by me to the best of my skill and ability.

I certify that the transcript fees and format comply with those prescribed by the Court and Judicial Conference of the United States.

This the 11th day of June, 2019.

s/ Brenda D. Wolverton
U.S. DISTRICT COURT REPORTER